

# Novel Homeopathic Approaches to Treating and Preventing Ulcerative Colitis and Other Intestinal Ailments Based Upon Novel Hypotheses

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## Introduction

A sharp rise in the incidence of Ulcerative Colitis (UC) and Crohn's Colitis over the past two decades has not been properly investigated. Behavioral causes are being dismissed in favor of declaring these ailments to be idiopathic autoimmune disorders treatable only with extremely expensive modified antibody-based treatments.

## Abstract

Autoimmune activity in the large intestine associated with UC and Crohn's Colitis, although associated with microbiomic activity, only indirectly results from the activity of the microbiome.

Recent research findings concerning eczema suggest that individuals with both eczema and Crohn's may notice that eczema's dermal flare-ups correspond with Crohn's flare-ups. Eczema has been known for quite some time to be made worse by the heating of the dermis.

I propose that the autoimmune component of conditions such as UC and Crohn's are thermally triggered and that the thermal energy bursts effecting acute autoimmune reactions is the cause of UC flare-ups. This contention is supported by the exceptional capacity of the anaerobic bacteria of the large intestine to generate heat, particularly when provided with glucose.

Although the large intestine is *almost* always a purely anaerobic environment, the bacterial microbiome consists of a variety of bacteria which, although all are adversely affected by the presence of oxygen, features species of bacteria which are more sensitive than others to oxygen. Problematic bacteria including *C. Difficile* are extreme anaerobes, meaning that even trace amounts of oxygen would likely destroy such bacterial colonies.

Other recent research suggests that the digestive benefits of lettuce are associated with the introduction of nutrients and enzymes which promote the growth of so-called healthy bacteria but which serve no function in human biology. Although these results may be partially true, I propose that this is not the primary reason that consuming vegetables such as lettuce promotes a healthy digestive system.

Lettuce is almost completely unique in the world of vegetables in that it features mechanisms which expel oxygen from the leaf which sit in front of empty, fluid-filled vacuoles which support CO<sub>2</sub>-oxygen exchange. Although vitamins are concentrated in the darker-green colored ends of the leaves, the lighter-colored celery-like stalks of the lettuce are, in fact, responsible for lettuce's digestive benefits.

I propose that oxygen is drawn into vacuoles and lingers there for a time due to an intrinsically inefficient CO<sub>2</sub>-oxygen exchange process which calls for a larger than average buffer to support this exchange. Although many of these vacuoles are ruptured during the mastication process, not all of them may be ruptured. Because lettuce is difficult to digest, stomach acids may not be sufficient to corrode the thick cell walls protecting these vacuoles.

Consequently, atmospheric O<sub>2</sub> can be encapsulated in lettuce and may be released into the large intestine as a natural consequence of latent effects of stomach acids on the cell walls of the lettuce. In the case wherein a vacuole releases its contents after lettuce enters the large intestine, it could be expected to release a burst of O<sub>2</sub> which would be tolerated moreso by the “healthy” bacteria than by the extreme anaerobes known to cause intestinal ailments.

What’s more, the regular introduction of small quantities of atmospheric O<sub>2</sub> via lettuce intake may reduce the overall bacterial load within the large intestine. When a person suffering from UC or Crohn’s Colitis ingests sugars of any sort, a greater than normal quantity of extreme anaerobes act to metabolize any sugars making their way into the large intestine and this, in turn, leads to heat generation. This heat-generation, I propose, leads to dilatory autoimmune effects which cause symptoms to be triggered at unexpected times and creates confusion as to the underlying cause of the symptoms. Certain food such as chocolate which both contain sugar and which are slower to digest may be chief culprits in dilatory thermal effects leading to symptoms. This hypothesis may be verified by performing a study involving a series of oral-route sensors which measure the temperature of the intestine at various points in the digestive process at varying lengths of time after digesting different sorts of foods. A patient might be asked to swallow a sensor prior to consuming something rich in sugar, another one hour afterward, another two hours afterward, etc. Such a study might reveal that the ingestion of chocolate results in a thermal increase in the large intestine which maximizes, on the average, eight hours after ingestion, ultimately triggering an immune response which sets in, on the average, 10 hours after ingestion. In order to bring about this effect, however, a quantity of chocolate, for example, must be consumed which is sufficient to ensure that it is not entirely digested in the small intestine, thereby ensuring the introduction of a food source sufficient to cause heat generation by extreme anaerobes. In an individual with no history of UC or other intestinal ailments, only modest heat generation likely takes place as a result of the ingestion of such foods whereas in a known UC patient, a more pronounced thermal increase would be anticipated. The consumption of whole lettuce leaves could be predicted to result, conversely, in thermal decreases; a finding which would support the core hypothesis.

One reason that the so-called “FODMAP diet” has been demonstrated to be effective in mitigating such symptoms is because the food source for the extreme anaerobic bacteria is being cut off. Although this may be helpful in alleviating symptoms, this does not rid a person of such an intestinal ailment entirely as it does not restore a more healthy balance of bacteria. It is only through the introduction of dietary sources of atmospheric oxygen capable of

reaching the large intestine, coupled with a moderate-carbohydrate diet through which a healthier balance of bacteria may be restored.

This insight has implications for procedures such as fecal-matter transplant, which have been used to treat conditions such as drug-resistant *C. Difficile* infection. One shortcoming of that treatment approach is that its rate of efficacy is only about 50%. I would posit that the reason why this treatment has been observed to be effective in only 50% of cases is, in fact, related to the volume of the container used for storing the healthy sample prior to the transplantation procedure as well as the duration of storage.

When these samples are stored in larger containers, a greater quantity of oxygen exists within the container which may infiltrate into the sample and be absorbed into the various bacterial colonies which one intends to introduce via the procedure. If the sample is stored for too short or too long a period of time, the transplant does not effect the introduction of sufficient quantities of atmospheric O<sub>2</sub> into the large intestine and therefore does not act to eradicate the resident *C. Difficile*. FM sample absorption of atmospheric oxygen during the storage process results in the delivery of an FM mass which is devoid of the unhealthy anaerobes one wishes to eliminate and which, owing to the tendency of those anaerobes to absorb large quantities of oxygen, results in the transplantation procedure delivering sufficient amounts of O<sub>2</sub> to the large intestine to eradicate the extant *C. Difficile*. This, when coupled with the use of FM samples of the proper consistency and careful dietary restrictions during the 24 hours after the procedure allows for O<sub>2</sub> to remain present for a sufficient length of time in each subsection of the large bowel in order to ensure the complete eradication of the infection. Paying careful attention to the aforementioned factors could improve the rate of efficacy of this procedure to near 100% and could lead to the development of alternatives to the procedure which could be equally effective in light of a more complete understanding of the mode of treatment.

## **Conclusion**

If this hypothesis is verified, it may be ,ultimately, possible to eliminate such invasive bacterial species such as both *C. Difficile* as well as those which exacerbate UC and Crohn's by the oral-route introduction of oxygen-rich encapsulated fluids which have detrimental effects upon problematic bacterial species.

I would, furthermore, speculate that the excessive consumption of over-the-counter antacids are creating exactly the sort of alkaline environment which favors extreme anaerobes over other anaerobic bacterial species and are the primary driver of new UC cases with the secondary driver being the over-consumption of carbohydrate-rich beverages including soft and hard mixed drinks. The over-consumption of these sorts of beverages results in chronic heartburn which is treated; frequently at the advice of doctors; with powerful antacids including Proton-Pump Inhibitors rather than addressing the underlying cause of the heartburn. This combination of a high-sugar diet and the consumption of antacids over a period of time seems to coincide with the inception of many cases of chronic UC and yet this observation has yet to be formalized by the research community.